STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

In the matter of:

STEPHEN J. SWARTZ, M.D. CONSENT ORDER

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon the Board's receipt of a report from the Medical Practitioner Review Panel (the "Panel") detailing findings and recommendations made by the Panel upon conclusion of an investigation of information reported regarding Respondent Stephen J. Swartz, M.D. Specifically, the Panel initiated an investigation upon receipt of a malpractice payment report detailing that a payment of $400,000 was made on Respondent's behalf to settle a civil malpractice action brought by the estate of patient A.C., wherein it had been alleged that Respondent was responsible for an eighteen month delay in
diagnosing lung cancer, which cancer ultimately caused A.C.’s death.

During the course of its investigation, the Panel considered available information, to include copies of the medical records that respondent maintained for A.C., reports of imaging studies ordered by Respondent and expert reports prepared during the pendency of the malpractice action. The Panel additionally considered testimony offered by Respondent when he appeared before the Panel for an investigative hearing on October 27, 2017. Respondent is represented in this matter by Alex J. Keoskey, Esq.

The Panel found that Respondent was A.C.’s primary care physician, having provided care to her dating back to April 2002. Respondent treated A.C. for conditions including chronic obstructive pulmonary disease, cardiovascular disease, hypertension, diabetes and obesity. On June 16, 2008, A.C., who was then 65 years old, contacted respondent’s office complaining of a bad persistent cough. Respondent ordered blood work and a chest x-ray to rule out congestive heart failure. The chest x-ray demonstrated patchy densities in the left upper lobe, which the radiologist suggested could be a mass or an infiltrate.

On June 23, 2008, Respondent saw A.C. in his office, and reviewed the chest x-ray with her. Respondent recorded “abnormal CXR” in his office notes, and recommended that A.C. have a repeat chest x-ray performed within one month. That repeat chest x-ray
was not, however, timely performed, and A.C. did not return to Respondent’s office the following month.

Respondent next saw A.C. four months later on October 13, 2008, for a general physical examination. Although Respondent had A.C.’s medical chart available, he did not discuss A.C.’s failure to have obtained the recommended repeat chest x-ray during her visit, nor did he document any notes in A.C.’s medical record regarding the continuing need for her to obtain a chest x-ray.

On November 7, 2008, Respondent saw A.C. for bulging at the base of her neck, and he then ordered CT scans of the neck and chest. A CT scan of the chest, performed on November 19, 2008, revealed a 4.2 x 2.6 cm mass in the left upper lobe which was reported to be “probably a malignancy.” That report was faxed from the Imaging Center where the CT scan was performed to Respondent’s medical office on November 20, 2008, and a copy of the faxed report was included in A.C.’s chart. When appearing before the Panel, Respondent testified that he “missed” the report, and therefore neither reviewed the report nor communicated the findings of a probable malignancy to A.C.

Respondent did not see A.C. again until December 8, 2009, when she presented for evaluation of dizziness and double vision. Respondent then ordered additional imaging studies, to include a CT scan of the chest. The December 2009 CT scan revealed that A.C.’s left upper lobe mass had increased in size to 5.2 x 2.7 cm.
Respondent informed A.C. of the CT findings on December 17, 2009, and A.C. was thereafter diagnosed with lung cancer, with metastases.

When appearing before the Panel, Respondent conceded that he failed to follow-up on the recommendation he made in June 2008 that A.C. obtain a repeat chest x-ray, and that he should have addressed the continuing need for a chest x-ray with A.C. when he examined her on October 13, 2008. Respondent further conceded that he should have followed-up to obtain the results of the chest CT scan in November 2008. Respondent testified that he has since made efforts to guard against similar lapses occurring in the future, to include having made changes to his general medical practice and his record keeping practices.

The Panel found that respondent engaged in repeated acts of negligence. Specifically, the Panel found that Respondent engaged in negligence: (1) when he failed to follow-up on the recommendation he made in June 2008 that A.C. have a repeat chest x-ray performed in one month (at a minimum, that failure should have been discussed and documented in Respondent’s medical chart when he examined A.C. in October 2008), and (2) when he failed to obtain and review the results of the CT scan of the chest which he ordered in November 2008, and to then communicate the findings of a probable malignancy directly to A.C. The Panel concluded that both acts of negligence contributed to a substantial delay in the
ultimate diagnosis of A.C.'s lung cancer. The Panel thus found that grounds for disciplinary action against respondent exist pursuant to N.J.S.A. 45:1-21(d). The Board subsequently adopted all findings made by the Panel.

The parties desiring to resolve this matter without need for further administrative proceedings, and the Board being satisfied that good cause exists for entry of the within Order:

IT IS on this 23rd day of February 2018

ORDERED and AGREED:

1. Respondent Stephen J. Swartz, M.D., is hereby reprimanded for having engaged in repeated acts of negligence when providing medical care to patient A.C., for the reasons set forth in greater detail above.

2. Respondent is assessed a civil penalty in the amount of $5,000, which penalty shall be payable in full, by certified check or money order (or by any alternative payment method deemed acceptable by the Board) at the time of entry of this Order.

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By: 
Paul J. Carnioli, M.D.
Board President

I represent that I have carefully read and considered
this Order, understand its terms, agree to comply with those terms and consent to the entry of the Order by the Board.

Stephen J. Swartz, M.D.

Dated: 2-16-18

Consent to form of Order and to entry of the Order by the Board.

Alex J. Keoskey, Esq.
Counsel for Respondent

Dated: 2-17-18
NOTICE OF REPORTING PRACTICES OF BOARD REGARDING DISCIPLINARY ORDERS/ACTIONS

All Orders filed by the New Jersey State Board of Medical Examiners are "government records" as defined under the Open Public Records Act and are available for public inspection, copying or examination. See N.J.S.A. 47:1A-1, et seq., N.J.S.A. 52:14B-3(3). Should any inquiry be made to the Board concerning the status of a licensee who has been the subject of a Board Order, the inquirer will be informed of the existence of the Order and a copy will be provided on request. Unless sealed or otherwise confidential, all documents filed in public actions taken against licensees, to include documents filed or introduced into evidence in evidentiary hearings, proceedings on motions or other applications conducted as public hearings, and the transcripts of any such proceedings, are "government records" available for public inspection, copying or examination.

Pursuant to N.J.S.A. 45:9-22, a description of any final board disciplinary action taken within the most recent ten years is included on the New Jersey Health Care Profile maintained by the Division of Consumer Affairs for all licensed physicians. Links to copies of Orders described thereon are also available on the Profile website. See http://www.njdoctorlist.com.

Copies of disciplinary Orders entered by the Board are additionally posted and available for inspection or download on the Board of Medical Examiners’ website. See http://www.njconsumeraffairs.gov/bme.

Pursuant to federal law, the Board is required to report to the National Practitioner Data Bank (the "NPDB") certain adverse licensure actions taken against licensees related to professional competence or conduct, generally including the revocation or suspension of a license; reprimand; censure; and/or probation. Additionally, any negative action or finding by the Board that, under New Jersey law, is publicly available information is reportable to the NPDB, to include, without limitation, limitations on scope of practice and final adverse actions that occur in conjunction with settlements in which no finding of liability has been made. Additional information regarding the specific actions which the Board is required to report to the National Practitioner Data Bank can be found in the NPDB Guidebook issued by the U.S. Department of Health and Human Services in April 2015. See http://www.npdb.hrsa.gov/resources/npdbguidebook.pdf.
Pursuant to N.J.S.A. 45:9-19.13, in any case in which the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, the Board is required to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders entered by the Board is provided to the Federation on a monthly basis.

From time to time, the Press Office of the Division of Consumer Affairs may issue press releases including information regarding public actions taken by the Board.

Nothing herein is intended in any way to limit the Board, the Division of Consumer Affairs or the Attorney General from disclosing any public document.